Behavioral Health Council Care Navigators

EMERGENCY DEPARTMENT TO OUTPATIENT TREATMENT REFERRAL PATHWAY

THE BEHAVIORAL HEALTH COUNCIL CARE NAVIGATORS

In the fall of 2012, the Behavioral Health Council was formed with the objective of guiding meaningful system-wide change. Bringing together providers, advocates, and consumers from across the behavioral health community, the Council is empowered to advocate for policy change, influence funding, and communicate with the larger community.

While challenges remain, the Behavioral Health Council and other partners have made considerable strides toward improved behavioral health for all New Orleanians. This report outlines the work and efforts of the Behavioral Health Council, emphasizing new improvements and additions to our understanding of the behavioral health capacity in New Orleans. It specifically highlights developments in data sharing and information exchange, youth mental health services, and collaborative projects from criminal justice, education, housing, and health and hospitals, and behavioral health stakeholders.

Purpose of the Care Navigators

The Behavioral Health Council's Health and Hospitals workgroup consists of administrators of local hospitals and local behavioral health treatment providers and advocates. The group's mission is to improve system-wide data collection used in the Behavioral Health Dashboard to better analyze causes of emergency department boarding and other times of psychiatric saturation.

Through the Health and Hospitals workgroup, the Care Navigators subgroup was established. This group's goal is to identify and assess any gaps that exist between the emergency department and outpatient referral process for patients with behavioral health needs.

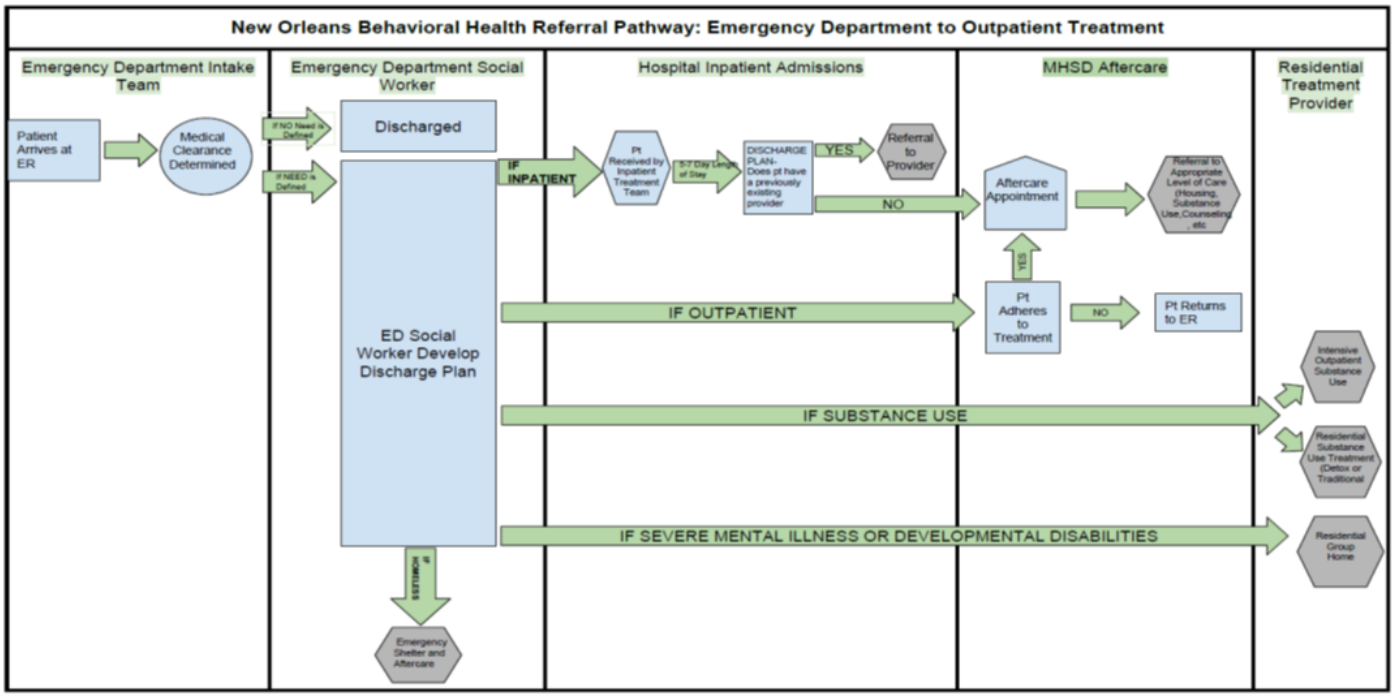
Membership

The Care Navigators subgroup has representation from the following groups:

- Aetna
- Amerigroup
- AmeriHealth Caritas
- Children's Hospital
- Council on Alcohol and Drug Abuse
- Emergency Medical Services
- Louisiana Public Health Institute
- Louisiana Health Care Connection
- Metropolitan Human Services District
- New Orleans East Hospital
- New Orleans Police Department
- New Orleans Health Department
- Touro Hospital
- Tulane Hospital
- United Healthcare
- University Medical Center
- Vialink

EMERGENCY DEPARTMENT TO OUTPATIENT TREATMENT REFERRAL PROCESS

The Behavioral Health Council's Care Navigators Subgroup consists of social workers and intake/discharge coordinators of local hospitals and outpatient providers, as well as representatives of the managed care organizations. This group's mission is to understand the discharge and referral coordination among various levels of care, inpatient and outpatient. As a result of multiple meetings, the group was able to establish the *Emergency Department to Outpatient Treatment Referral Process Map*. This map identifies the treatment options available for various levels of care after emergency department discharge of patients with behavioral health needs.



PATHWAY

Level 1- Intake

Level One is the Emergency Department Intake Level. This level consists of the local hospital's emergency department (ED) teams. When the patient arrives at the local ED, the ED staff determines medical clearance for the patient. Medical clearance is based upon the medical needs of the client. If no need is determined, the patient would be discharged. If a need is determined, the emergency department social work team would help to determine the next course of action.

Level 2- ED Social Worker

At this level, the emergency department social work staff determines the appropriate discharge plan. Discharge options include home, inpatient admissions, outpatient treatment, emergency shelter/aftercare facility, and residential treatment facilities.

The four emergency department discharge pathways are as follows:

Discharge Pathway One- Emergency Shelter

When the patient is discharged by the emergency department team and does not have a physical home address, the patient has the option to be discharged to an emergency shelter or aftercare facility. This process includes being connected to shelters, transitional housing, or aftercare facilities.

Discharge Pathway Two- Hospital Inpatient Admissions

One discharge option includes being released to an inpatient hospital. If transferred to the hospital, the patient is received by the hospital's inpatient treatment team. The average length of inpatient stay is five to seven days. There, the proper care is provided followed by the appropriate discharge plan. Discharge plans may include referral to a provider or aftercare appointment Metropolitan Human Services District (MHSD).

Discharge Pathway Three- MHSD Aftercare

If a patient requires specific aftercare treatment after an inpatient stay, the patient may be connected with Metropolitan Human Services District, the region's local human services agency. There, the patient will be assessed and then connected to the appropriate treatment facility based upon the level of care needed. This may include care in terms of housing, substance use, counseling, etc.

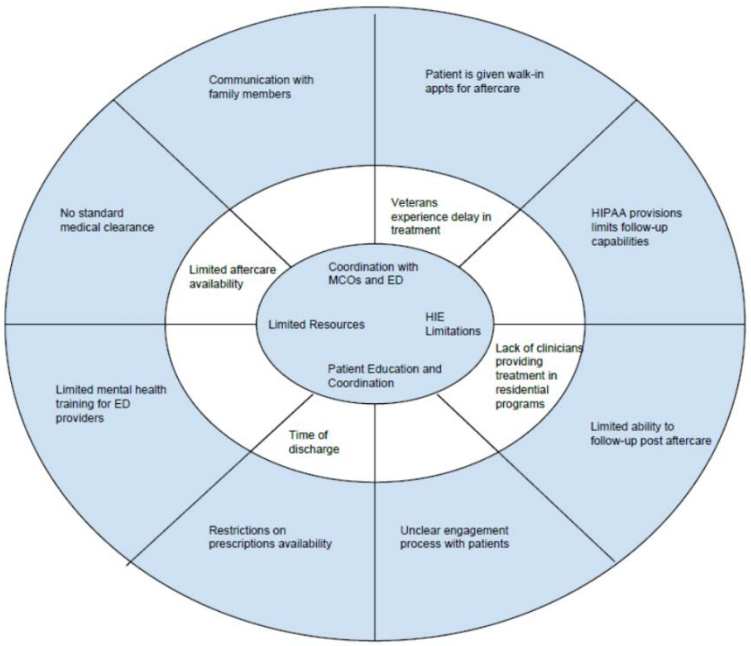
If the patient is not inpatient, and was provided outpatient care instructions, MHSD's aftercare may still the most appropriate treatment option. Again, after assessment, the patient will be connected to the appropriate treatment facility.

Discharge Pathway Four - Residential Treatment Provider

If the patient suffers from a substance use disorder, then it would be on this pathway that the patient is connected to the most appropriate treatment. This may include intensive outpatient substance use treatment, residential substance use treatment, and residential group homes.

IDENTIFIED BARRIERS

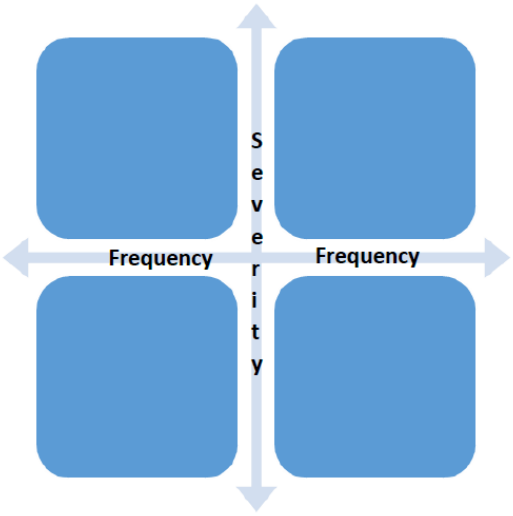
Once the pathway was developed, the Care Navigators subgroup identified the various barriers that patients may encounter in the process of trying to access services and treatment. Some barriers discussed were underlying and critical, while others were not as intense. The barriers were categorized by core, inner and outer levels to describe their severity. The core level describes the most frequent and severe barriers. These barriers were most intense and presented many challenges. At the middle level, these barriers have a mixed range of frequency and severity.



At the outer level, while these barriers were just as critical, they were not presented as often or as severe as the aforementioned barriers.

At the core level, underlying barriers included:

- Coordination between managed care organizations and emergency departments
- Limited resources
- Health Information Exchange (HIE) limitations
- Patient's education and coordination



At the inner level, barriers that existed included:

- Limited aftercare availability
- Lack of clinicians providing treatment in residential programs
- Time of discharge
- Veterans experiencing delay in treatment

At the outer level, barriers included:

- No standard medical clearance
- Communication with family members
- Patient is given walk-in appointments for aftercare
- HIPAA provisions limits follow-up capabilities
- Unclear engagement process with patients
- Restrictions on prescriptions availability
- Limited mental health training for emergency department providers

RECOMMENDATIONS

The group discussed potential solutions to many of the barriers previously described. The proposed solutions corresponded into three categories as described below.

Health Communications: Patient to Provider, Provider to provider, Community Health Education

In the Health Communications category, solutions were targeted around incorporating ways to increase education between healthcare providers, patients, and community. Solutions included:

- Provider to Provider Communications
    - Enhancing coordination between emergency department and managed care organizations (MCOS)
    - MCOs sending case managers to hospitals to continue coordinating process
    - Developing "MCO Education and Awareness" seminars for hospital staff
    - In-service trainings for medical documentation
- Patient to Provider Communications
    - Increased communications with patients – phones, times of discharge, etc.
    - Providing phones to patients

- Enhancing ways to obtain additional emergency contacts from patients
- Creating a centralized location for a message board for relaying messages to patients.

Health Information Exchange and Data Sharing Systems

In the Data Sharing Category, the group discussed opportunities that exist within health information exchanges and data sharing systems. Proposed solutions include:

- Incorporate providers, outreach workers, and outpatient treatment into one electronic workflow
- Combine the two local Health Information Exchange (HIE) systems
- Develop an interactive system to show the availability of rehabilitation beds

Wraparound Services & Program Development

There were several discussions that focused around the need for additional services and resources in the area. Additional programs to support coordination or care included:

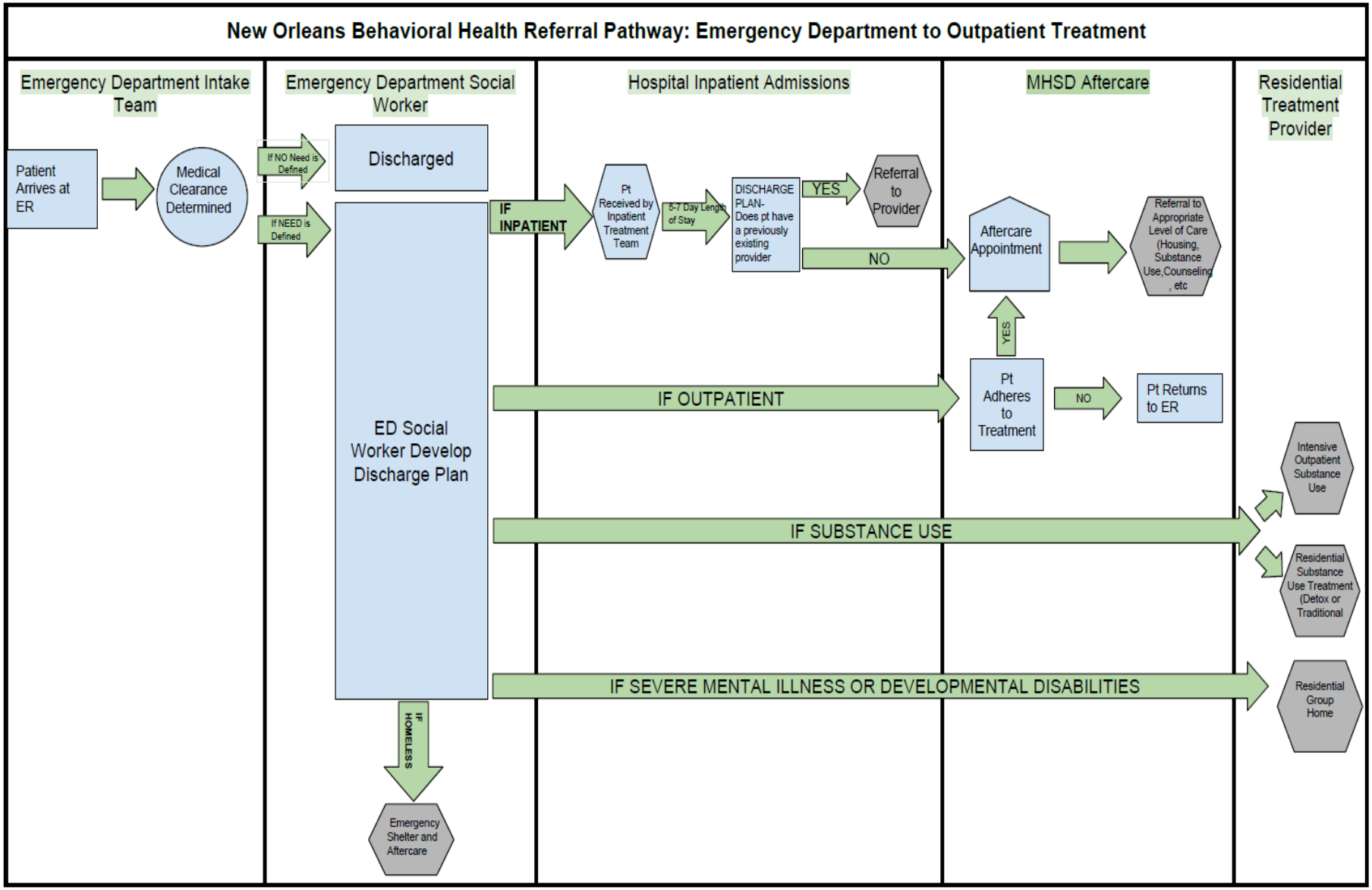
- Crisis stabilization services
- Low-barrier shelter
- Sobering centers with holistic approaches
- Inpatient rehab options
- Additional medically assisted detox programs

CONCLUSIONS

Though the recommended solutions are not exhaustive nor comprehensive, they have been identified as ways to close gaps and coordinate care for patients in the city. What is needed is increased collaboration and integration between the health and hospital sectors. Through the City's Behavioral Health Council, the Care Navigators subgroup was able to elaborate on what that collaboration may look like. By developing the ED to Outpatient Referral Pathway, we are able to better understand the emergency department to outpatient referral process, barriers to care, and opportunities to eliminate gaps in care coordination.

Appendix

A. Emergency Department to Outpatient Referral Pathway



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B. Prioritized Barriers